STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #29396 were completed on March 12 - 14, 2012. No deficiencies were cited related to complaint investigation #29396 under 42 CFR Part 482, requirements for Long Term Care Facilities.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain a physician's order prior to insertion of an indwelling urinary catheter for two resident (#2,#3) of twenty-three residents reviewed. The findings included: Resident #2 was admitted to the facility on December 15, 2011, with diagnoses including Unspecified Cerebrovascular Disease, Atrial Fibrillation, Chronic Obstructive Airway Disease, Hypertension, Depressive Disorder, Encephalopathy, Diabetes Mellitus, Spinal Stenosis, and Dysphagia. Medical record review of Nurse's Notes dated January 21, 2012 through January 30, 2012, revealed the resident had an indwelling urinary catheter. Continued medical record review of Nurse's	F 281	F281 Residents affected Resident #2 a telephone order for Foley Catheter was obtained on 01/21/12 prior to insertion. An order to remove the Foley was obtained on 01/30/12 and the catheter was removed. Resident #3 the Foley Catheter was removed 01/21/12. Residents Potentially Affected Residents with orders for foley catheter who were discharged to hospital then readmitted to facility have the potential to be affected by the alleged deficient practice. All residents readmitted after discharge to hospital since 1/1/12 have been audited to ensure current orders for foley catheters are correct. Measures/Systematic Changes Licensed nursing staff have been reeducated on importance of having current order for foley catheter prior to insertion. If obtaining telephone or verbal order and the importance of entering order in computer in a timely manner.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Chitwood	Executive Director	3/28/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 281	Continued From page 1 Notes dated January 21, 2012, January 22, 2012, January 23, 2012, and January 24, 2012, revealed "incontinent of bowel and bladder at times." Further medical record review of Physician's Recapitulation Orders signed February 21, 2012, revealed "Foley cath (indwelling urinary catheter) #16 (size of catheter) with 5 ml (milliliter) bulb to bed side drainage bag d/t (due to) retention. BSDB (bedside drainage bag) change Q (every) 2 weeks. Foley cath change Q MONTH on MONDAY-Once daily Specific days of week: Mon" with an order and start date of January 24, 2012. Observation on March 12, 2012, at 10:52 a.m., in the resident's room, revealed the resident up in a wheelchair with no evidence of an indwelling urinary catheter. Interview with the Unit Manager on March 14, 2012, at 8:10 a.m., at the North Wing Nurse's Station, confirmed the resident returned from the hospital on January 19, 2012, without an indwelling urinary catheter. Continued interview confirmed the resident had an indwelling catheter from January 21, 2012, to January 30, 2012. Further interview with the Unit Manager confirmed the resident had an indwelling urinary catheter placed January 21, 2012, and the physician's order for the indwelling urinary catheter was not written until January 24, 2012. Resident #3 was admitted to the facility on January 20, 2012, with diagnoses including Intracranial Cerebral Hemorrhage (brain bleed),	F 281	Monitoring Changes The Assistant Director of Nursing or RN Supervisor will audit readmission and admission orders within 24 hours to verify Foley orders. Residents who are readmitted, these charts will be audited weekly x (4) four weeks and monthly times (2) two months and quarterly times (1) one quarter to ascertain residents assessment has been completed and documented in medical record and the Plan of Care revised as appropriate. The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	4/23/12

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F 281	Continued From page 2 History of Atrial Fibrillation (abnormal heart rhythm), Right Sided Weakness, Hypertension (high blood pressure), Dysphasia (difficulty swallowing) secondary to Intracranial Hemorrhage, Status Post Endovascular Stent secondary to Abdominal Aortic Aneurysm, Depression, and Anxiety. Medical record review of the Nursing Admission Assessment dated January 20, 2012, at 6:58 p.m, revealed "...transported to facility via ambulance...incontinent of B&B. Foley cath (indwelling urinary catheter) patent and draining cloudy urine..." Medical record review of the Nurses Notes revealed the resident was incontinent January 24-29, 2012. Continued medical record review of the Nurses Notes revealed the resident had an indwelling urinary catheter on January 30 - February 1, 2012, February 5, 2012, and February 10, 2012. Further medical record review of a Progress Note dated February 15, 2012, revealed "..foley is out..." Interview with the Unit Manager and the Director of Nursing (DON) on March 14, 2012, at 8:30 a.m., in the DON's office, confirmed an indwelling urinary catheter was inserted on January 21, 2012, and removed the same day without an active order from the physician.	F 281		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 3 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain infection control for one resident (#14) of twenty- three residents reviewed.	F 441	**F441** Residents affected Resident #14 the gloves were immediately removed upon discovery. Residents Potentially Affected Residents served trays in their room have the potential to be affected by the alleged deficient practice. Measures/Systematic Changes Nursing staff have been re-educated on infection control practices related to the proper use and disposal of gloves. Monitoring Changes Director of Nursing or RN Supervisor will audit infection control practices during random meals at random times via observation to ascertain infection control practices are being maintained. Audits will be performed weekly for four (4) weeks, monthly for two (2) months and then quarterly.	

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F 441	Continued From page 4 The findings included: Resident #14 was admitted to the facility on February 23, 2012, with diagnoses including, Congestive Heart Failure, Sepsis, Chronic Obstructive Pulmonary Disease, Chronic Diarrhea, and Depression. Medical record review of the Minimum Data Set Dated March 6, 2012, revealed the resident to be cognitively intact, independent in decision making, and required assistance with eating. Observation on March 13, 2012, at 8:03 a.m., in the resident's room, revealed the resident staring at the breakfast tray on the over bed table. Continued observation from 8:03 a.m. until 8:07 a.m., revealed a pair of vinyl gloves turned inside out, lying inside the plate cover on the over bed table beside the breakfast tray. Continued observation revealed the resident was not eating foods from the breakfast plate. Interview with the resident on March 13, 2012, at 8:07 A.M., in the resident's room revealed "those aren't mine." Interview with the Unit Manager on March 13, 2012, at 8:09 a.m., in the resident's room, confirmed the presence of the gloves in the resident's breakfast plate cover,and the gloves were to be disposed of immediately after use.	F 441	The results of the audits will be reviewed at the Quality Assurance Committee which includes: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services. The committee meets monthly and will review the audit observations for three (3) months and recommendations made as appropriate.	4/23/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 5 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately document the presence of an indwelling catheter on two residents (#2), (#3), of twenty-three residents reviewed. The findings included: Resident #2 was admitted to the facility on December 15, 2011, with diagnoses including Unspecified Cerebrovascular Disease, Atrial Fibrillation, Chronic Obstructive Airway Disease, Hypertension, Depressive Disorder, Encephalopathy, Diabetes Mellitus, Spinal Stenosis, and Dysphagia. Medical record review of Nurses Notes dated January 21, 2012, at 10:20 a.m.; January 22, 2012, at 10:26 a.m.; January 23, 2012, at 10:20 a.m.; January 24, 2012, at 12:20 a.m. and 5:17 p.m.; January 25, 2012, at 2:34 p.m.; January 26, 2012, at 1:15 p.m.; January 27, 2012, at 11:41 a.m.; January 28, 2012, at 10:47 a.m.; January 29, 2012, at 11:45 a.m. and January 30, 2012, at 1:11 p.m., revealed documentation the resident	F 514	F514 Residents Affected Resident #2 and resident # 3 were affected. Residents Potentially Affected Residents who have had foley catheters and/or drainage bag have the potential to be affected by the alleged deficient practice. Any resident who has had a foley catheter since 1/1/12 that has since been discontinued has had chart audit for appropriate documentation. Measures/Systematic Changes Licensed Nursing staff have been re-educated on documentation of resident with Foley Catheters.	

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F 514	Continued From page 6 had an indwelling catheter. Continued medical record review of the Nurses Notes dated January 21, 2012, at 3:12 p.m.; January 22, 2012, at 9:55 p.m.; January 23, 2012, at 6:28 a.m. and January 24, 2012, at 1:40 a.m., revealed documentation the resident was "incontinent of bowel and bladder at times." Interview with the Unit Manager on March 14, 2012, at 8:10 a.m., at the North Wing Nurse's Station confirmed the resident had an indwelling catheter from January 21, 2012, until January 30, 2012, and nursing documentation did not accurately reflect the resident's status. Resident # 3 was admitted to the facility on January 20, 2012, with diagnoses including Intracranial Cerebral Hemorrhage (brain bleed), History of Atrial Fibrillation (abnormal heart rhythm), Right Sided Weakness, Hypertension (high blood pressure), Dysphasia (difficulty swallowing) secondary to Intracranial Hemorrhage, Status Post Endovascular Stent secondary to Abdominal Aortic Aneurysm, Depression, and Anxiety. Medical record review of the Nursing Admission Assessment dated January 20, 2012, at 6:58 p.m., revealed "...transported to facility via ambulance...incontinent of B&B. Foley cath (indwelling urinary catheter) patent and draining cloudy urine..." Medical record review of the Nurses Notes dated January 24-29, 2012, revealed the resident was incontinent of bowel and bladder. Medical record review of the Nurses Notes dated	F 514	Monitoring Changes IDP notes will be reviewed daily in start up to ensure documentation is consistent with POC. DON or ADON will audit 10(ten) records to ascertain care is being documented completely and accurately. Audits will be performed weekly for four (4) weeks, monthly for three (3) months. The results of the audits will be reviewed at the Quality Assurance Committee consisting of: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dinning Services. The Committee meets monthly and will review the outcomes documentation audit will be reviewed for three (3) months and recommendations made as appropriate.	4/23/12

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F 514	Continued From page 7 January 30, 2012, February 1, 2012, February 5, 2012, and February 10, 2012, revealed documentation the resident had an indwelling urinary catheter. Medical record review of a Progress Note dated February 15, 2012, revealed "foley is out." Further medical record review of a Physician's Order dated January 20, 2012, revealed "Foley cath #16 (catheter size) with 5ml (milliliter) bulb to bedside drainage bag. BSDB (bedside drainage bag) change Q (every) 2 WEEKS. Foley cath change Q MONTH on MONDAY. Discontinue Date 02/16/2012." Interview with the Unit Manager and Director of Nursing (DON) on March 14, 2012, at 8:20 a.m., in the DON's office confirmed the resident did not have an indewelling urinary catheter, and the medical record did not accurately reflect the resident's bladder status.	F 514		